

WEBSTER (D) & SCHWARZSCHILD (H.D.)

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REPRINTED FROM THE
New York Medical Journal
for February 16, 1895.





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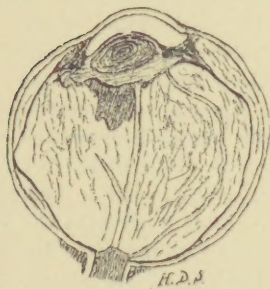
A MARRIED woman, aged thirty-five years, was admitted to my clinic at the Manhattan Eye and Ear Hospital on September 26, 1893. She said that on September 20th she had been wounded in the right eye by the small blade of a pocket knife. The wound commenced in the cornea at a point corresponding to the infero-nasal border of the pupil and extended downward and slightly inward, involving the entire width of the ciliary region. The eyelids were slightly swollen; the ocular conjunctiva deeply injected; the pupil irregularly dilated. There was very little pain either at the time of the injury or subsequently. R. V. = shadows. L. V. = $\frac{2}{3}$. Atropine was applied, and the patient was advised to remain in the hospital. She entered the hospital as a house patient the next day and was put to bed. Iced cloths and atropine were applied. After a few days the treatment was changed to bathing the eye with hot water for fifteen minutes every two hours. On October 2d the patient had improved so much that upon her solicitation she was allowed to go home. The vision was tested and found to be,

R. V., perception of light. L. V., $\frac{2}{3}$ without a glass; raised to $\frac{2}{3}$ with + 1 D. c. ax. 90° .

I saw the patient at my office on December 12th. A plastic cyclitis had set in, building up a yellowish-white mass behind the lens, and abolishing perception of light. There were blood-vessels converging from the infero-nasal quadrant of the conjunctiva to the cicatrix. The latter was slightly depressed, as though a circumscribed atrophy were beginning. The eyeball was soft, tension — 3. L. V. = $\frac{2}{3}$; $\frac{2}{3}$ with + 0.75 D. The left eye was watery and slightly sensitive to light. This was believed to be due to sympathetic irritation. On December 13th she was again admitted as an in-patient; ether was administered and the offending eye was enucleated. It was placed in Müller's fluid and given to Dr. H. Davison Schwarzschild for macroscopic and microscopic examination.

The left eye improved rapidly after the enucleation of the right, and the patient was discharged on December 17th. She wears an artificial eye with comfort.

Pathological Report and Remarks.—The eye showed marked diminution in tension, and a linear scar was visible at the sclero-corneal junction infero-nasally. A gross examination of the frozen section reveals a detached retina, coagulated exudation in the vitreous chamber, and an apparently organized membrane immediately posterior to the lens. The continuation of the cicatrix is seen to the external portion of the ciliary body, the path of the incision being directly backward and outward—*i. e.*, referring to the sclera, not to the position of the eye in the orbit. The chord subtends an arc of 30° .



Microscopically.—The cicatricial tissue is well formed and dense. The ciliary body has been the seat of a plastic inflammation

and has given rise to the exudation, which is composed of fibrin and is moderately rich in cells, forming a false mem-

brane in certain areas. The iris at its root is somewhat œdematous. The retina is enormously hyperplastic and in parts hæmorrhagic. The chorioid is atrophic and the optic nerve is almost imperceptibly involved, an extremely slight increase in the number of the connective-tissue nuclei and a moderate dilatation of the vena centralis being the only changes. By appropriate staining small colonies of the staphylococcus are visible in the ciliary body and the anterior part of the exudation.

This case again calls forth discussion on the subject of sympathetic inflammation. The same views which I expressed nearly two years ago I reiterate, if anything, even more emphatically.

The presence of bacteria has nothing whatever to do with the transmission of the inflammation from globe to globe. As a matter of fact, an eye which is full of pus rarely, if ever, affects its fellow-organ, the tendency being toward perforation and secondary atrophy. A highly infected penetrating instrument will be more apt to produce a violent panophthalmitis than a smouldering fire; on the other hand, an aseptic instrument injuring the ciliary body will occasion a plastic cyclitis and sympathetic ophthalmia.

As a result of microscopical examination in cases of sympathetic disease, I find that the ciliary body is intimately connected with the exudation, which is usually more or less fibrinous; the latter exerts traction on the ciliary processes and irritates the nerves, producing the inexplicable reflex.

The iris and ciliary body are also very frequently incarcerated in the cicatrix, producing a constriction of the nerves. Although the optic nerve is in many cases involved in the exciting eye, the lesion in the sympathizing one is an irido cyclitis of varying intensity, and but rarely an optic neuritis. These few latter cases have fostered the theory of direct transmission *via* the vaginal sheath; but

the involvement of the iris and ciliary region can never be explained thereby. Sympathetic inflammation is most likely to occur about six weeks after the reception of the injury; it may occur sooner, and sometimes not till ten years later, particularly if there be an ossific plate in the chorioid. It may be stated in general terms that if one eye is affecting the other, the former should be removed.

If, when we see a patient for the first time, both are more or less equally diseased, it is not advisable to enucleate either at once, for sometimes the sympathizing one becomes blind and the other improves. In certain cases the first eye may suffer from serous cyclitis or a moderately subacute iritis with or without traumatic cataract, and the other have well marked sympathetic symptoms; here also both should be symptomatically treated, and we should temporize and keep up a careful surveillance of the eyes. The exciting eye, if blind or so badly affected that we can not hope to obtain useful vision, should be enucleated.

Naturally, the best results are obtained by removing the globe when the sympathizing eye is just entering the prodromic period (sympathetic irritation), and the longer we wait, *cæteris paribus*, the worse the prognosis.

Contrary to the generally accepted view, it is possible, even after sympathetic inflammation has developed, to cure it by enucleating the exciting eye.

The New York Medical Journal.

A WEEKLY REVIEW OF MEDICINE.

EDITED BY

FRANK P. FOSTER, M.D.

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PUBLISHED BY

D. APPLETON & CO., 72 Fifth Avenue, New York.

